MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-026193

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6858 STATE FILE NUMBER

FILED JUL 5 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis
Length of stay in Ib 1 hr.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis County
c. CITY OR TOWN Richmond Heights
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 7723 Dale
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Eileen Middle Last Monahan
4. DATE OF DEATH Month 6 Day 30 Year 63
5. SEX F
6. COLOR OR RACE W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 4/1/63
9. AGE (last birthday) IF UNDER 1 YEAR Months 3 Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) St Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Malachy Monahan
13b. MOTHER'S MAIDEN NAME Erlene Buechman
14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of se
14. SOCIAL SECURITY NO.
17. INFORMANT Address Mr. M. Monahan 7723 Dale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Upper Respiratory Infection & toxemia — 10 days
DUE TO (c) 493.x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pt was a Congenital Deficient Mongoloid type
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 4/1/63 to 6/30/63 and last saw her/him alive on 6/20/63
Death occurred at 8:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) Chas Mungmd
22b. ADDRESS 8005 Big Bend Webster Groves 19, Mo.
22c. DATE SIGNED 7/1/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7/2/63
23c. NAME OF CEMETERY OR CREMATORY Calvary
23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR ADDRESS Jas. A. Howard 1619 So. Grand
25. DATE RECD. BY LOCAL REG. JUL 1 1963
26. REGISTRAR'S SIGNATURE Boad Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. Wm. Brunkin

Licensed Embalmer No. 3613

P. O. Address Ft Lauderdale Fla

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.